REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. P3 Charity Head Office Eagle House, Cotmanhay Road, Ilkeston, Derbyshire DE7 8HU**
1	**CORONER** I am Mrs Joanne Lees, Area Coroner for the Black Country.
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013 https://www.legislation.gov.uk/uksi/2013/1629/part/7
3	**INVESTIGATION and INQUEST** On 21/2/22 I commenced an investigation into the death of Mr Keith Holmes dob 6/11/72 who died aged 49 on 30/12/21. The investigation concluded at the end of the inquest on 4/5/22. The inquest was heard before myself sitting without a Jury and my conclusion at inquest was one of Accidental Death. The medical cause of Mr Holmes death was recorded as 1a) Fatal Asphyxia 1b) Smoke Inhalation (Fire Induced) At inquest, I made the following findings of fact; In the early hours of 30/12/21 Fire services responded to a report of a fire at McHugh House, 89-95 Dickens Road, Wolverhampton. A fire alarm at the property had been activated and the fire discovered by an on-duty night manager. Firefighters entered [redacted] where there was a fully developed fire and Mr Holmes was discovered unresponsive on the floor under a window with his feet towards a bed. Smoking materials were observed near the bed. Mr Holmes was removed from the room and confirmed as deceased at the scene. A post mortem confirmed Mr Holmes died from smoke inhalation. A Fire Investigation failed to determine whether the fire was caused by an electrical fault involving a fridge in Mr Holmes room, due to extensive damage to the fridge, or, by the ignition of Mr Holmes' clothing or bedding caused by smoking materials which then transferred burning material closer to the fridge.
4	**CIRCUMSTANCES OF THE DEATH** 1. Mr Holmes had been residing in [redacted] at McHugh House, 89-95 Dickens Road Wolverhampton since 28/12/21. The property was a house of multiple occupation leased from Wolverhampton City Council by the Charity known as P3 (People Potential Possibilities). He had been accommodated at McHugh House (referred to as the property or Dickens Lodge) as part of the local authorities winter accommodation provisions as Mr Holmes had become homeless. He was allocated [redacted].

	2. In the early hours of 30/12/21 the night manager at McHugh House was alerted by an alarm of a fire on the second floor. The fire was originating from within Mr Holmes's room and was fully developed by the time fire fighters arrived. Mr Holmes was found unresponsive in his room and confirmed as deceased shortly afterwards. A Fire Investigation failed to determine whether the fire was caused by an electrical fault involving a fridge in Mr Holmes room, due to extensive damage to the fridge, or, by the ignition of Mr Holmes' clothing or bedding caused by smoking materials which then transferred burning material closer to the fridge. 3. I heard in evidence that the fridge in room 13 had been supplied by P3 for use by Mr Holmes in his room. It was reported the fridge has been purchased over 2 years before the incident but the age of the fridge, make and model number was not recorded. There were no other electrical appliances in the room. 4. **I was told in evidence that P3 had a policy whereby Portable appliance testing (hereafter referred to as PAT) was carried out by a member of P3 maintenance team on an annual basis**. 5. Prior to Mr Holmes moving into [redacted] on 28/12/21, the fridge had last been PAT tested on 17/6/19 and was due to be retested in June 2020. P3 accepted that the PAT testing was out of date at the time Mr Holmes moved into room 13 on 28/12/21. P3 gave evidence that the Covid restrictions imposed by the UK Government were such that annual PAT testing could not take place during the pandemic. The reason why was not fully explained. 6. I was told that P3 maintenance operatives who would ordinarily undertake the PAT testing had been placed on furlough in 2020. 7. P3 told me in evidence that the Covid restrictions meant residents were expected to spend a significant period of each day in their room. 8. P3 told me in evidence that the Charity had not conducted any further risk assessment in view of there being an increased risk of fire or accident posed by unmaintained electrical appliances whilst Covid restrictions were in place and access to the property was limited. 9. P3 told me that despite the Covid restrictions which prevented PAT testing, that there had been a yearly fire risk assessment carried out on 22/4/21 at the property which identified the PAT testing as being out of date. No further risk assessment was conducted, and no other action was taken. 10. P3 told me in evidence that they had a contract with OHEAP Fire and Security but had not asked for any advice from them with regard to reassessing the risk posed by the PAT testing not taking place. 11. P3 told me in evidence they had not taken any advice on how to manage the increased risks from the Fire Service. 12. P3 told me in evidence they had not taken any advice from either the local authority or any other organisation on how to manage the increased risk of fire or accident posed by unmaintained electrical appliances presented by the PAT testing of electrical appliances in McHugh house being out of date. 13. P3 told me in evidence that they were unaware of any guidance issued by the Health & Safety executive regarding PAT testing during the pandemic (see HSE Guidance April 2021). 14. P3 did give evidence that the Charity had maintained a system of monthly and weekly room checks at the property. This included a visual check of electrical points for any sign of damage. They also told me a visual check was also undertaken on 21/12/21 and shortly before Mr Holmes moved into [redacted]. 15. Most lockdown restrictions in the UK were lifted on 4 July 2020. The fire in Mr Holmes room occurred on 30/12/21. P3 told me in evidence that furloughed P3 maintenance operatives responsible for PAT testing had only recently returned to work and that PAT testing had only resumed in McHugh House on 10/1/22.
5	**<u>CORONER'S CONCERNS</u>** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you.

	The **MATTERS OF CONCERN** are as follows. – (1) There was an increased risk of fire or accident due to unmaintained electrical equipment during the Covid 19 pandemic; (2) P3 failed to carry out a reassessment of the increased risks posed by the non-testing of electrical appliances in McHugh House during the Covid 19 Pandemic. This was during a time when it was expected that residents would spend significant periods of each day in their room; (3) I was told in evidence that P3 do not have a contingency plan on managing the increased risks posed by the absence of PAT testing in the event the UK is placed into a similar lockdown situation as experienced during 2020/2021.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 4/7/22. I, the coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons [redacted]. I have also sent it to Wolverhampton City Council as landlord of the premises who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response.
9	**[DATE]** **5/5/22**  Area Coroner